METHODS AND STANDARDS FOR ESTABLISHING FACILITY-SPECIFIC REIMBURSEMENT RATES FOR FREESTANDING SKILLED NURSING FACILITIES LEVEL-B AND SUBACUTE CARE UNITS OF FREESTANDING SKILLED NURSING FACILITIES

I. Introduction

A. This document, labeled Supplement 4 to Attachment 4.19-D, describes the overall reimbursement rate methodology for skilled nursing facility services provided to Medi-Cal recipients by: (1) freestanding skilled nursing facilities level-B (FS/NF-B), both publicly and privately operated, and (2) subacute care units of FS/NF-Bs as defined in California Code of Regulations, title 22, section 51124.5.

B. This Supplement is submitted by the single State Medicaid (Medi-Cal) Agency, the State of California Department of Health Services (hereinafter "Department"). This Supplement is necessary to describe changes to the FS/NF-B reimbursement rate methodology adopted by the 2004 State Legislature in Assembly Bill (AB) 1629, signed into law on September 29, 2004, as Chapter 875 of the Statutes of 2004.

C. AB 1629 establishes the Medi-Cal Long-Term Care Reimbursement Act, which mandates a facility-specific rate-setting methodology effective on August 1, 2005; and which will cease to be operative on and after July 31, 2008. This statute requires the Department to develop and implement a Medi-Cal cost-based facility-specific reimbursement rate methodology for Medi-Cal participating FS/NF-Bs, including FS/NF-Bs with subacute care beds. AB 203, signed into law on August 24, 2007, as Chapter 188 of the Statutes of 2007, extends the operative date to July 31, 2009. AB 1183, signed into law on September 30, 2008, as Chapter 758 of the Statutes of 2008, extends the operative date to July 31, 2011.SB 853, signed into law on October 19, 2010, as Chapter 717 of the Statutes of 2010, extends the operative date to July 31, 2012. ABX1 19, signed into law on June 28, 2011, as Chapter 4 of the Statutes of 2011, extends the operative date to July 31, 2013. AB 1489, signed into law on September 27, 2012, as Chapter 631 of the Statutes of 2012, extends the operative date to July 31, 2015.

D. The cost-based reimbursement rate methodology is intended to reflect the costs and staffing levels associated with the quality of care for residents in FS/NF-Bs. This methodology will be effective August 1, 2005, and will be implemented the first day of the month following federal approval. A retroactive increase in reimbursement rates to August 1, 2005, to FS/NF-Bs will be provided in the event that federal approval occurs after the effective date of the methodology.

E. The reimbursement rates established will be based on methods and standards described in Section V of this Supplement.

F. Provisions of this legislation require that the facility-specific reimbursement rates for rate years 2005/06 and 2006/07 will not be less than the rates developed based upon the methodology in effect as of July 31, 2005, as described in Attachment 4.19-D, Pages 1 through 22 of the State Plan, plus projected proportional costs for new state or federal mandates for the applicable rate years.

II. General Provisions

A. Within the provisions of this Supplement, the following abbreviation will apply: FS/NF-B meaning freestanding level-B nursing facility.

B. Reimbursement to FS/NF-Bs (excluding those with FS/NF-B subacute beds) will be for routine per diem services, exclusive of ancillary services. The reimbursement rate for these ancillary services are reviewed and audited by the Department and are reimbursed separately.

C. The routine service per diem reimbursement rate will be consistent with Medicare Reimbursement Principles as specified in Title 42, Code of Federal Regulations, Part 413. Aggregate Medi-Cal payments may not exceed the aggregate payments that the state would pay for the same or similar services under the Medicare Prospective Payment System.

D. The FS/NF-B routine service per diem payment includes all equipment, supplies and services necessary to provide appropriate nursing care to long-term care residents, except those items listed as separately payable, as described in the California Code of Regulations, title 22, section 51511(c), or personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility and periodic hair cuts performed as part of resident care), and television rental.

E. For subacute care units of FS/NF-Bs the per diem payment includes all services, equipment and supplies necessary for the administration of the treatment procedures for residents determined to need subacute care services. Items included in the reimbursement rate are specified in the California Code of Regulations, title 22, section 51511.5(d).

F. Notwithstanding any other provisions of this State Plan, the per diem payment will be limited to the usual charges made to the general public, as described in the California Code of Regulations, title 22, section 51501.

G. All long-term care providers must be licensed and certified to participate in the Medi-Cal program and must meet the requirements of the California Code of Regulations, title 22, section 51200. In order to assure that reimbursement rates take into account the cost of compliance with statutory requirements, FS/NF-Bs will be reimbursed according to this Supplement based on the following resident acuity levels:

1. Freestanding NF-B residents;
2. Freestanding subacute ventilator-dependent residents;
3. Freestanding subacute non-ventilator-dependent residents.

H. FS/NF-B subacute care facilities provide medically necessary services of varying degrees of higher intensity care, as provided in the California Code of Regulations, title 22, section 51124.5.

III. Cost Reporting

A. All long-term care FS/NF-Bs participating in the Medi-Cal Program will maintain, according to generally accepted accounting principles, the uniform accounting systems as described in California Code of Regulations, title 22, section 51511.2 and will submit cost reports in the manner approved by the state.

B. Cost reports are due to the state no later than 120 days after the close of each facility's fiscal year, in accordance with Medi-Cal cost reporting requirements.

C. Each FS/NF-B will retain its supporting financial and statistical records for a period of not less than three years following the date of submission of its cost report and will make such records available upon request to authorized state or federal representatives, as described in Welfare and Institutions Code section 14124.1.

D. All cost reports will be prepared according to the Office of Statewide Health Planning and Development's (OSHPD) Reporting Requirements and Instructions. These cost reports will be maintained by the state for a period of not less than five years following the date of electronic submission of reports, in accordance with Title 42, Code of Federal Regulations, section 433.32.

E. The reimbursement rate methodology for FS/NF-Bs may include more or less than twelve months and/or more than one cost report, as long as the fiscal periods all end within the timeframe specified for rate-setting. Only cost reports accepted by the OSHPD will be included in the calculation of the facility-specific reimbursement rates, except as specified in Section VIII of this Supplement.

F. For FS/NF-Bs providing subacute care services, only cost reports with twelve or more months of subacute costs which have been formally accepted by the state will be used in the rate study to determine the facility-specific reimbursement rate.

G. Supplemental schedules may be used to augment and/or update cost reports and other source data used to develop facility-specific rates. Supplemental schedules will be subject to audit or review prior to use in the facility-specific rate-setting process.

H. The Department reserves the right to exclude any cost report or supplemental schedule or portion thereof that it deems inaccurate, incomplete or unrepresentative.

I. FS/NF-Bs that no longer participate in the Medi-Cal program will be excluded from the rate-setting process.

J. For purposes of calculating reasonable compensation of facility administrators, the Department will adhere to the standards established under Chapter 9 of the Centers for Medicare & Medicaid Services Provider Reimbursement Manual (HIM 15), reproduced in full in Volume 2 at Paragraph 5577 of the Commerce Clearing House Medicare and Medicaid Guide. The Department will conduct its own compensation survey for calculating reasonable compensation for facility administrators. Based on the data collected from such surveys, the state will develop compensation range tables for the purpose of evaluating facility administrator compensation during audits of those FS/NF-Bs, and adjust the costs accordingly.

IV. Audits and Audit Adjustments

A. The Department will conduct financial audits of FS/NF-Bs participating in the Medi-Cal program a minimum of once every three years. These audits may be full-scope field audits, limited scope reviews, or desk reviews. Limited scope or desk reviews will be conducted at intervening periods, as necessary. All subacute care units of FS/NF-Bs will be subject to audit or review on an annual basis.

B. The Department will adjust or reclassify reported cost and statistical information submitted by the FS/NF-Bs for the purposes of calculating facility-specific Medi-Cal rates consistent with applicable requirements of this Supplement and as required by Title 42, Code of Federal Regulations, Part 413.

C. Audited or reviewed cost data and/or prospective audit adjustments will be used and/or applied to develop facility-specific reimbursement rates.

1. On an annual basis, the Department will use FS/NF-B cost reports, including supplemental reports as required by the Department, and the results of any state or federal audits to determine if there is any difference between the reported costs used to calculate a FS/NF-B's reimbursement rate and the FS/NF-B's audited expenditures in the rate year.

2. If the Department determines that there is a difference between reported costs used to calculate a FS/NF-B's reimbursement rate and the audited facility expenditures, the Department will adjust the FS/NF-B's

reimbursement rate prospectively over the intervening year(s) between audits. The amount a cost category is adjusted will be determined by an error factor that reflects a ratio of the difference between the reported cost and the audited expenditures for each cost category, consistent with the methodology specified in this Supplement.

D. In the event that the FS/NF-B's labor costs are incorrectly reported on facility cost reports or supplemental schedules, the Department will prospectively adjust the facility's reimbursement rate, in the same manner as described in Section IV.C.2. of this Supplement. Those adjustments received after computation of the annual labor study will be excluded from that study.

E. Compliance by each FS/NF-B with state laws and regulations regarding staffing levels will be documented annually, either through supplemental reports or through the annual licensing inspection process specified in Health and Safety Code section 1422.

F. Overpayments to any FS/NF-B will be recovered in a manner consistent with applicable recovery procedures and requirements of state and federal laws and regulations. Overpayment recovery regulations are described in the California Code of Regulations, title 22, section 51047. Overpayments referred to in this Section do not include those situations described above in Paragraphs IV.C.2. or IV.D.

G. Providers have the right to appeal audit or examination findings that result in an adjustment to Medi-Cal reimbursement rates. Specific appeal procedures are contained in Welfare and Institutions Code, section 14171, and in Division 3, Subdivision 1, Chapter 3, Article 1.5 (Provider Audit Appeals) of the California Code of Regulations, title 22, sections 51016 through 51048.

H. For FS/NF-Bs that obtain an audit appeal decision that results in revision of the facility's allowable costs used to calculate a facility's reimbursement rate, the Department will make a retroactive adjustment in the facility-specific reimbursement rate.

V. Methods and Standards for Establishing FS/NF-B Reimbursement Rates

A. Effective August 1, 2005, a FS/NF-B's actual reimbursement rate (per diem payment) is the amount the Department will reimburse to a FS/NF-B for services rendered to an eligible resident for one resident day. The per diem payment is calculated prospectively on a facility-specific basis using facility-specific data from the FS/NF-B's most recent cost report period (audited or adjusted), supplemental schedules, and other data determined necessary by the Department.

B. The prospective per diem payment for each FS/NF-B is computed on a per resident day basis. For the rate year beginning August 1, 2010, and for subsequent years, professional liability insurance costs are included as a major cost category. The per diem payment is comprised of the following major cost categories:

1. labor costs
2. indirect care non-labor costs
3. administrative costs
4. professional liability insurance costs
5. capital costs
6. direct pass-through costs.

Payment for FS/NF-Bs will be based on facility-specific cost-based reimbursement rates consisting of the major cost categories, and determined as described in the following Section V.C. of this Supplement.

C. Cost Categories. The facility-specific cost-based per diem payment for FS/NF-Bs is based on the sum of the projected costs of the major cost categories, each subject to ceilings described in this Section. Costs within a specific cost category may not be shifted to any other cost category. In addition, per diem payments will be subject to overall limitations described in Section VI of this Supplement.

1. The labor cost category is comprised of a direct resident care labor cost component, an indirect care labor cost component, and a labor-driven operating allocation cost component. For the rate year beginning August 1, 2010, and for subsequent years, the labor-driven operating allocation cost component is eliminated. These components are comprised of more specific elements described below:

   a. Direct resident care labor costs include salaries, wages, and benefits related to routine nursing services personnel, defined as nursing, social services, and activities personnel. Direct resident care labor costs include labor expenditures associated with a FS/NF-B's permanent direct care employees, as well as expenditures associated with temporary agency staffing. These costs are limited to the 90th percentile of each FS/NF-B's respective peer-group, as described in Section VII of this Supplement.

      i. For the rate year beginning August 1, 2005, and for subsequent rate years, the direct resident care labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report, as adjusted for audit findings. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 90th percentile of each FS/NF-B's peer-grouped allowable Medi-Cal direct

resident care labor cost per diems. FS/NF-B's will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

ii. An inflation index, based on the Department's labor study, developed from the most recently available industry-specific historical wage data as reported to OSHPD by providers will be applied to the FS/NF-B's allowable direct resident care labor per diem costs. Each facility's direct resident care labor costs will be inflated from the mid-point of the cost reporting period or supplemental schedule reporting period to the mid-point of the rate year.

b. Indirect care labor costs include all labor costs related to staff supporting the delivery of resident care including housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance costs. These costs are limited to the 90th percentile of each facility's respective peer-group, as described in Section VII of this Supplement.

i. In-service education activities are defined as education conducted within the FS/NF-B for facility nursing personnel. Salaries, wages and payroll-related benefits of time spent in such classes by those instructing and administering the programs will be included as in-service education labor costs. If instructors do not work full-time in the in-service education program, only the cost of the portion of time they spend working in the in-service education program is allowable. In-service education does not include the cost of time spent by nursing personnel as students in such classes or costs of orientation for new employees. The costs of nursing in-service education supplies and outside lecturers will be reflected in the in-service education non-labor costs of the indirect care non-labor cost category.

ii. For the rate year beginning August 1, 2005, and for subsequent rate years, the indirect resident care labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the facility's most recently available cost report, as adjusted for audit findings. Each facility's per diem payment will be limited to a ceiling amount, identified as the 90th percentile of each facility's peer-grouped allowable Medi-Cal indirect

Resident care labor cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

iii. An inflation index, based on the Department's labor study, developed from the most recently available industry-specific historical wage data as reported to OSHPD by providers will be applied to the FS/NF-B's allowable indirect resident care labor per diem costs. Each facility's indirect resident care labor costs will be inflated from the mid-point of the cost reporting period or supplemental schedule reporting period to the mid-point of the rate year.

c. Labor-driven operating allocation includes an amount equal to eight percent of direct and indirect resident care labor costs, less expenditures for agency staffing, such as nurse registry and temporary staffing agency costs. The labor-driven operating allocation may be used to cover allowable Medi-Cal expenditures incurred by a FS/NF-B to care for Medi-Cal residents. In no instance will the operating allocation exceed five percent of the facility's total Medi-Cal reimbursement rate. For the rate year beginning August 1, 2010, and for subsequent rate years, the labor driven operating allocation is eliminated as a cost component for the labor cost category.

2. Indirect care non-labor costs include the non-labor costs related to services supporting the delivery of resident care, including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education and plant operations and maintenance costs. These costs are limited to the 75th percentile of each facility's respective peer-group, as described in Section VII of this Supplement.

a. For the rate year beginning August 1, 2005, and for subsequent rate years, the indirect care non-labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report, as adjusted for audit findings. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 75th percentile of each FS/NF-B's peer-grouped allowable Medi-Cal indirect care non-labor cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

b. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to the FS/NF B's allowable indirect care non-labor per diem costs to inflate costs from the mid-point of the cost reporting period to the mid-point of the rate year.

3. Administrative costs include allowable administrative and general expenses of operating the facility, including a FS/NF-B's allocated expenditures related to allowable home office costs. The administrative cost category will include allowable property insurance costs, and exclude expenditures associated with caregiver training, liability insurance, facility license fees, and medical records. For the rate year beginning August 1, 2010, and subsequent rate years, legal and consultant fees are excluded as stated below.

   a. For the rate year beginning August 1, 2005, and for subsequent rate years, the administrative per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report or supplemental schedule, as adjusted for audit findings. For purposes of establishing reimbursement ceilings, each FS/NF-B will be peer-grouped as described in Section VII of this Supplement. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 50th percentile of the allowable Medi-Cal administrative cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

   b. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to the FS/NF-B's allowable administrative per diem costs to inflate costs from the mid-point of the cost reporting period to the mid-point of the rate year.

   c. For the rate year beginning August 1, 2010, and for subsequent rate years, the administrative cost category will exclude any legal or consultant fees in connection with a fair hearing or other litigation against or involving any government agency or department until all issues related to the fair hearing or litigation issues are ultimately decided or resolved in favor of the FS/NF-B's.

4. For the rate year beginning August 1, 2010, and for subsequent rate years, the professional liability per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report or supplemental schedule, as adjusted for audit findings. For purposes of establishing reimbursement ceilings, each FS/NF-B will be peer-grouped as described in Section VII of this Supplement. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 75th percentile of the allowable Medi-Cal cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount. FS/NF-Bs must report the insurance deductibles in a format and by the deadline determined by the Department, or the deductibles will be reimbursed at the 50th percentile in the administrative cost category.

5. Capital costs. For the rate year beginning August 1, 2005, and for subsequent rate years, a Fair Rental Value System (FRVS) will be used to reimburse FS/NF-B's property (capital) costs. Under the FRVS, the Department reimburses a facility based on the estimated current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, rent or lease payments. The FRVS establishes a facility's value based on the age of the facility. For rate years subsequent to 2005/06, additions and renovations (subject to a minimum per-bed limit) will be recognized by lowering the age of the facility. The facility's value will not be affected by sale or change of ownership. Capital costs, limited as specified below in Section V.C.4.e. of this Supplement, are derived from the FRVS parameters as follows:

   a. The initial age of each facility is determined as of the mid-point of the 2005/06 rate year, using each facility's original license date, year of construction, initial loan documentation, or similar documentation. For the 2005/06 rate year, all FS/NF-Bs with an original license date of February 1, 1976, or prior, will have five years subtracted from their facility age to compensate for any improvements, renovations or modifications that have occurred in the past. The age of each facility will be adjusted every rate year to make the facility one year older, up to a maximum age of 34 years.

   b. For the 2006/07, 2007/08, 2008/09, 2009/10, 2010/11 and for subsequent rate years costs incurred for major capital improvements, modifications or renovations equal to or greater than $500 per bed on a total licensed-bed basis will be converted into an equivalent number of new beds, effectively lowering the age of the facility on a proportional basis. If a facility adds or replaces beds, these new beds will be averaged in with the age of the original beds, and the weighted average age of all beds will represent the facility's age. If a facility performs a major renovation or replacement project (defined as a project with capitalized cost equal to or greater than $500 per bed, on a total bed basis), the cost of the renovation project will be converted to an equivalent number of new beds. The equivalent number of new beds would then be used to determine the weighted average age of all beds for the facility.

   c. The FRVS per diem calculation, subject to the limitations identified in Section V.C.4.e. of this Supplement, is calculated as follows:

i. An estimated building value will be determined based on a standard facility size of 400 square feet per bed, each facility's licensed beds, and the R.S. Means Building Construction Cost Data, adjusted by the location index for each locale in the State of California. The estimated building value will be trended forward annually to the mid-point of the rate year using the percentage change in the R.S. Means Construction Cost index.

ii. An estimate of equipment value will be added to the estimated building value in the amount of $4,000 per bed.

iii. The greater of the estimated building and equipment value or the fully depreciated building and equipment value will be determined for each facility (hereinafter, the "current facility value"). The fully depreciated building and equipment value is based on a 1.8 percent annual depreciation rate for a full 34 years.

iv. An estimate of land value will be added to the current facility value based on ten percent of the estimated building value as calculated in Section V.4.C.c.i. of this Supplement.

v. A facility's fair rental value is calculated by multiplying the facility's current value plus the estimated land value, times a rental factor. The rental factor will be based on the average 20-year U.S. Treasury Bond yield for the calendar year preceding the rate year plus a two percent risk premium, subject to a floor of seven percent and a ceiling of ten percent.

vi. The facility's fair rental value is divided by the greater of actual resident days for the cost reporting period, or occupancy-adjusted resident days, based on the statewide average occupancy rate. Days from partial year cost reports will be annualized in the FRVS per diem payment calculation.

d. Continued explanation and examples of the FRVS per diem calculations follow:

Example of FRVS Per Diem Calculation

Example Assumptions

Building License Date = 2/1/1976
Actual Age on 2/1/2006 (mid-point of 2005/06 rate year) = 30 years
Effective Age for FRVS = 25 years (subtract 5 years for improvements)
Rental Factor = 7 percent
Construction Cost = $123 per square foot
Occupancy = 90% = 30,715 resident days
Licensed Beds = 99
Facility Location = San Diego = 1.061 location index

Base Value Computation

Estimated Building Value (99 beds x 400 square feet x $123 x 1.061)	$ 5,167,919
Add: Equipment Value at $4,000 per bed	$ 396,000
Gross Value	$ 5,563,919
Depreciation (1.8% x 25 years)	$ 2,503,764
Net Value (undepreciated current facility value)	$ 3,060,155
Add: Land Value at 10% of Undepreciated Building Value	$ 516,792
Total Base Value	**$ 3,576,947**

FRVS Per Diem Calculation

Fair Rental Value (rental factor x total base value)	$ 250,386
FRVS per diem (Fair Rental Value + occupancy adjusted resident days)	**$ 8.15**

Example of FRVS Per Diem Calculation With Improvement Modification

Example Assumptions

Original Building Assumptions Remain Static	
Cost of Remodel	$ 500,000
Remodel Cost Per Bed ($500,000 ÷ 99 beds)	$ 5,051
Base Value Per New Bed Prior to Improvement Modification (gross value ÷ 99 beds)	$ 56,201

Modified Facility Age Calculation

Equivalent Number New Beds (cost of remodel ÷ base value/bed before improvement)	8.9

Weighted Average Age

Prior to Improvement – 99 Beds x 25 years	2,475
Resulting from Improvement – 8.9 Beds x 0 years	0
Total = 107.9 Beds	2,475
Weighted Average Age = 2,475/107.9	**22.9 Years**

Modified Base Value Computation

Gross Value (Building and Equipment)	$ 5,563,919
Adjusted Depreciation = 1.8% x 22.9 years x gross value	$ 2,293,447
Modified Net Value	$ 3,270,472
Add: Land Value	$ 516,792
Modified Total Base Value	**$ 3,787,264**

Modified FRVS Per Diem Calculation

FRVS Per Diem (rental factor x modified base value)/(total resident days)	**$ 8.63**

e. The capital costs based on FRVS will be limited as follows:

i. For the 2005/06 rate year, the capital cost category for all FS/NF-Bs in the aggregate will not exceed the Department's estimate of FS/NF-B's capital reimbursement for the 2004/05 rate year, based on the methodology in effect as of July 31, 2005.

ii. For the 2006/07, 2007/08, 2008/09, 2009/10, 2010/11 and for subsequent rate years, the maximum annual increase for the capital cost category for all FS/NF-Bs in the aggregate will not exceed eight percent of the prior rate year's FRVS aggregate payment.

iii. If the total capital cost category for all FS/NF-Bs in the aggregate for the 2005/06 rate year exceeds the value of the capital cost category for all FS/NF-Bs in the aggregate for the 2004/05 rate year, the Department will reduce the capital cost category for each and every FS/NF-B in equal proportion.

iv. If the capital cost category for all FS/NF-Bs in the aggregate for the 2006/07, 2007/08, 2008/09, 2009/10, 2010/11 and for subsequent rate years exceeds eight percent of the prior rate year's cost category, the Department will reduce the capital FRVS cost category for each and every FS/NF-B in equal proportion.

6. Direct pass-through costs are comprised of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, liability insurance costs, the Medi-Cal portion of the skilled nursing facility quality assurance fee, and new state and federal mandates for the applicable rate year. For the rate year beginning August 1, 2010, and for subsequent rate years, liability insurance costs are excluded from the direct-pass-through cost category.

a. For the rate year beginning August 1, 2005, and for subsequent rate years, the Medi-Cal proportional share of the pass-through per diem costs will be calculated as the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report and/or supplemental schedule(s), as adjusted for audit findings.

b. Caregiver training costs are defined as a formal program of education that is organized to train students to enter a caregiver

occupational specialty. Until the Medi-Cal cost report is revised to specifically identify these costs, FS/NF-Bs will be required to complete an annual supplemental report detailing these expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting.

c. The Medicare reimbursement principles consistent with Title 42, Code of Federal Regulations, Part 413 will be used to determine reasonable allowable pass through costs for professional liability insurance. FS/NF-Bs will be required to complete an annual supplemental report detailing these expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting. For the rate year beginning August 1, 2010, and for subsequent rate years, liability insurance costs are excluded from the direct pass-through cost category.

d. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to update caregiver training costs and liability insurance costs from the mid-point of the cost report period or supplemental report period to the mid-point of the rate year. For the rate year beginning August 1, 2010, and for subsequent rate years, liability insurance costs are excluded from the direct pass-through cost category.

e. Property tax pass-through costs will be updated at a rate of two percent annually from the mid-point of the cost report period to the mid-point of the rate year.

f. Facility-license fee pass-through costs and the Medi-Cal portion of the skilled nursing facility quality assurance fee will be applied on a prospective basis for each rate year, and will not require an inflation adjustment.

D. For the 2005/06 and 2006/07 rate years, the facility-specific Medi-Cal reimbursement rate calculated under the methodology set forth in Section V of this Supplement will not be less than the Medi-Cal reimbursement rate that the FS/NF-B would have received under the rate methodology in effect as of July 31, 2005, plus Medi-Cal's projected proportional costs for new state or federal mandates for rate years 2005/06 and 2006/07, respectively.

E. Pursuant to AB 1629, the details, definitions and formulas may be set forth in regulations and provider bulletins or similar instructions.

F. The Department will establish reimbursement rates pursuant to AB 1629 on the basis of facility cost data reported in the Integrated Long-Term Care Disclosure and Medi-Cal Cost Report required by Health and Safety Code section 128730 for the most recent reporting period available and cost data reported in other facility financial disclosure reports, supplemental reports, or surveys required by the Department.

G. The percentiles in labor costs, indirect care non-labor costs, and administrative costs will be based on annualized costs divided by total resident days and computed on a geographic peer-group basis. For the rate year beginning August 1, 2010, and for subsequent rate years, professional liability costs will be based on annualized costs divided by total resident days and computed on a geographic peer-group basis.

VI. Limitations on the Medi-Cal Facility-Specific Reimbursement Rate Calculation

In addition to limitations described in Section V.C.4.e. of this Supplement (FRVS reimbursement limitations), the aggregate facility-specific Medi-Cal payments calculated in accordance with the methodology set forth in Section V of this Supplement will be limited by the following:

A. For the 2005/06 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed eight percent of the weighted average reimbursement rate for the 2004/05 rate year, as adjusted for the change in the cost to the FS/NF-B to comply with the skilled nursing facility quality assurance fee for the 2005/06 rate year, plus the total projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

B. For the 2006/07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed five percent of the weighted average Medi-Cal rate for the 2005/06 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

C. For the 2007/08 and 2008/09 rate years, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 5.5 percent of the weighted average Medi-Cal rate for the 2006/07 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

D. For the 2009/10rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not be increased over the weighted average Medi-Cal rate for the 2008-09 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

E. For the 2010/11 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3.93 percent of the maximum annual increase in the weighted average rate from the 2009/10 rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

F. For the 2011/12 rate year, the maximum annual increase of each FS/NF-Bs Medi-Cal reimbursement rate will not exceed 2.4 percent from the rate effective May 31, 2011, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

G. For services provided on and after June 1, 2011 through July 31, 2012, Medi-Cal payments will equally be reduced by 10 percent. Specifically, for the period June 1, 2011 through July 31, 2011, the payment is based on the 2010-11 rate that would otherwise be paid to each FS/NF-B, reduced by 10 percent. Accordingly, for the period August 1, 2011 through July 31, 2012, the payment is based on the 2011-12 rate that otherwise would be paid to each FS/NF-B, reduced by 10 percent. The Department will determine the amount of reduced payments for each FS/NF-B, equivalent to the 10 percent payment reduction for the period beginning June 1, 2011, through July 31, 2012, and provide a supplemental payment to each FS/NF-B no later than December 31, 2012.

H. To the extent that the prospective facility-specific reimbursement rates are projected to exceed the adjusted limits calculated pursuant to VI.A, VI.B, VI.C, VI. D, VI. E, and VI.F of this Supplement, the Department will adjust the increase to each FS/NF-B's projected reimbursement rate for the applicable rate year by an equal percentage.

I. The payment reductions in the previous section(s) will be monitored in accordance with the monitoring plan at Attachment 4.19-F, entitled "Monitoring Access to Medi-Cal Covered Healthcare Services.

J. For the 2012/13 rate year, FS/NF-Bs will be reimbursed the facility specific Medi-Cal reimbursement rate effective on August 1, 2011, excluding the reductions specified in VI.G, plus the cost of complying with new state or federal mandates.

K. For the 2013/14 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3 percent of the maximum annual increase in the weighted average rate from the 2012/13 rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

L. For the 2014/15 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3 percent of the maximum annual increase in the weighted average rate from the 2013/14 rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

M. Beginning with the 2015/16 rate year through July 31, 2017, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 3.62 percent of the maximum annual increase in the weighted average rate from the previous rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

N. Beginning with the 2017/18 rate year through July 31, 2020, the annual increase in the weighted average Medi-Cal reimbursement rate shall be 3.62 percent of the weighted average rate from the previous rate year, plus the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates. Total Medi-Cal reimbursement shall not exceed any applicable federal upper payment limit.

VII. Peer-Grouping

The percentile caps for FS/NF-B facility labor, indirect care non-labor, administrative, and for the rate year beginning August 1, 2010 and subsequent rate years professional liability costs will be computed on a geographic peer-grouped basis. The median per diem direct resident care labor cost for each individual county will be subjected to a statistical clustering algorithm, based on commercially available statistical software. The statistical analysis of county costs will result in a defined and finite number of peer groups. A list of counties and their respective peer groups, along with a more detailed explanation of the peer-grouping methodology is available on-line at: http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCAB1629Policy.aspx, or by contacting the Department at:

California Department of Health Care Services
Medi-Cal Benefits, Waiver Analysis, and Rates Division/Long-Care System Development Unit
MS 4612
P.O. Box 997417
Sacramento, CA 95899-7417
Phone: (916) 552-9600

V. Determination of FS/NF-B Rates for State-Owned Facilities, Newly Certified Providers or Changes of Ownership

A. State-owned and operated FS/NF-Bs will receive a prospective payment rate based on the peer-group weighted average Medi-Cal reimbursement rate.

B. New FS/NF-Bs with no cost history in a newly constructed facility, in a location not previously licensed as a FS/NF-B, or an existing facility newly certified to participate in the Medi-Cal program will receive a reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate. The Department will calculate the facility-specific rate when a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective on August 1 of each rate year.

C. FS/NF-Bs that have a change of ownership or changes of the licensed operator where the previous provider participated in the Medi-Cal program, the new owner or operator will continue to receive the reimbursement rate of the previous provider. The Department will calculate the facility-specific rate when a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective on August 1 of each rate year.

D. 1. FS/NF-Bs decertified for less than six months and upon recertification will continue to receive the reimbursement rate in effect prior to decertification. The Department will calculate the facility-specific rate when a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective on August 1 of each rate year.

2. FS/NF-Bs decertified for six months or longer and upon recertification will receive a reimbursement rate based on the peer-group weighted average Medi-Cal reimbursement rate. The Department will calculate the facility-specific rate when a minimum of six months (12 months for subacute care units) of Medi-Cal cost data has been audited. The Department will calculate the rate prospectively and it will be effective on August 1 of each rate year.

IX. Quality and Accountability Supplemental Payment

A. For the rate years beginning August 1, 2017 and August 1, 2018, the Department will develop and implement the Skilled Nursing Facility Quality and Accountability Supplemental Payment (QASP) System. This program provides supplemental reimbursement for FS/NF-Bs, including FS/adult subacute facilities, that improve the quality of care rendered to its residents and would be in addition to the rate of payment FS/NF-Bs receive under the current reimbursement methodology.

B. The Department, in consultation with California Department of Public Health (CDPH) and representatives from the long-term care industry; organized labor; and consumers; has developed a three tiered scoring methodology, with improvement scoring, for supplemental payments. The Minimum Data Set data file is obtained from the Centers for Medicare & Medicaid Services (CMS). The Department has a data use agreement with the Health Services Advisory Group for such purposes.

1. 100 points are divided among the measurements with point values distributed for each quality indicator.

Measurement Area/Indicator	Possible Points:
Minimum Data Set Clinical	100.00
Facility Acquired Pressure Ulcer: Long Stay	11.111
Physical Restraints: Long Stay	11.111
Influenza Vaccination: Short Stay	5.55575
Pneumococcal Vaccination: Short Stay	5.55575
Urinary Tract Infection: Long Stay	11.111
Control of Bowel/Bladder: Long Stay	11.111
Self-Report Pain: Short Stay	5.55575
Self-Report Pain: Long Stay	5.55575
Activities of Daily Living: Long Stay	11.111
Direct Care Staff Retention	11.111
30 Day All-Cause Readmission	11.111

2. A facility's score for each indicator is as follows: a facility's performance is less than statewide average: zero points; at or above statewide average, up to but not including 75th percentile: half points; at or above the 75th percentile: full points. Indicators may be added or removed in the future, subject to state and CMS approval.

In determining the statewide average and the 75th percentile for each indicator, the performance of all facilities, including ineligible facilities as defined in paragraph C below, are included.

3. Facilities receive an overall quality of care score when points from each of the quality measures are totaled.

4. Facilities that score at least 50.00 points are eligible for QASP payments.

5. For the clinical quality measures, the prior state fiscal year (July 1 to June 30) performance is used for current rate year payment as well as determination of the 75th percentile and statewide average, except for the staff retention measure. For example, MDS data from the performance period of July 1, 2016 to June 30, 2017 will be used to make rate year 2017/18 payments.

   For the clinical quality measures, CDPH, in collaboration with the Department, computes each facility's score based on the MDS data. In using the MDS data file, the Long Stay Pressure Ulcer measure is adjusted so that unhealed pressure ulcers are not added back into the performance calculation.

   For the direct care staff retention measure, cost reports available from the Office of Statewide Health Planning and Development (OSHPD) for the audit period will be used. The measure will rank facilities based on the amount of direct nursing staff turnover during the reporting period, calculated by dividing "Number of Continuously Employed Direct Nursing Staff During the Report Period" by "Number of Direct Nursing Staff at the Beginning of the Report Period," with less turnover scoring higher.

6. Eligible facilities are grouped into three payment tiers based on their overall quality of care score. Facilities with scores from 0 to 49.99 points are grouped as Tier 1. Facilities with scores from 50.00 to 66.66 points are grouped into Tier 2. And facilities with scores from 66.67 to 100 points are grouped into Tier 3. Ineligible facilities, as defined in paragraph C, are grouped into Tier 0.

   Tier 0 and Tier 1 facilities will not receive any supplemental payments under this QASP program component. The total pool amount for this component is converted into a Tier 2 per diem and a Tier 3 per diem. The Tier 3 per diem is set at 1.5 times the Tier 2 per diem. Each facility within Tier 2 and Tier 3 will receive a supplemental payment equal to the respective tier per diem times the facility's number of Medi-Cal bed days (including Fee-For-Service and managed care days) for the audit period.

The formula for determining the Tier 2 and Tier 3 per diems is as follows:

Total pool = (Aggregate Tier 2 Medi-Cal bed days* x Tier 2 per diem) + (Aggregate Tier 3 Medi-Cal bed days* x 1.5 x Tier 2 per diem)

Tier 3 per diem = Tier 2 per diem x 1.5

* Medi-Cal bed days total for the audit period includes Fee-For-Service and managed care days

The Department will utilize audited Medi-Cal Fee-For-Service and managed care bed days for determining payment amounts. The audited bed days are drawn from the audit reports used to establish 2017/18 and 2018/19 Fee-For-Service per diem rates. Note that any facility that does not have any Medi-Cal Fee-For-Service days from audit period would not be included in the above computation and will not receive this payment.

Below is an example of a three tiered payment methodology:

Total Payout $90M

Payment Tier	Point Range	# of SNFs	Payout per MCBD	Total MCBDs per Tier	Total Payout per Tier	Ave Payout per SNF
Tier 0		346	$0.00	5,811,700	$0	$0
Tier 1	0 – 49.99	419	$0.00	10,280,958	$0	$0
Tier 2	50.00 – 66.66	211	$12.15	4,381,696	$53,237,607	$252,310
Tier 3	66.67 – 100	119	$18.23	2,019,628	$36,807,720	$309,307
Total Receiving Payment		**330** **30.14%**				**$272,865**

7. An additional component of the QASP program is the improvement scoring, where 10% of the payment allocation is set aside for facility improvements from the baseline year.

   A facility's overall quality of care score as determined in paragraph B during a performance period is compared to the facility's score from the immediate prior performance period (base period). For example, for rate year 14/15 payment purposes, the facility's score for its performance in the 13/14 period is compared to its score for performance in the 12/13 base period. The difference is the improvement score. The improvement score for all facilities are ranked. Tier 0 facilities in the performance period are not included in the ranking as they are ineligible and not assigned a score. Additionally, a Tier 1/2/3 facility in the performance period would not be included in the Improvement ranking if the facility: 1) did not have any Medi-Cal bed days in the base period; 2) did not have any MDS clinical measure data in the base period; or 3) is a new facility in the performance period. Facilities in the top 20th percentile in the improvement score ranking will receive a supplemental payment under the improvement component.

   The total improvement pool amount specified in paragraph B.8 below is divided by the total number of Medi-Cal bed days (including both Fee-For-Service and managed care days) for all facilities qualifying for an improvement component payment. The result is an improvement per diem. Each facility qualifying for an improvement component supplement payment

will receive a supplement payment equal to the improvement per diem times its number of Medi-Cal days (including Fee-For-Service and managed care).

The Medi-Cal days are derived from the same source as Medi-Cal days in paragraph B.6. Note that any facility that does not have any Medi-Cal Fee-For-Service days in the audit period would not be included in the above computation and will not receive this payment.

8. The aggregate supplemental payment amount for the 2017/18-rate year will be funded by a pool of $88,000,000, of which $2,000,000-will be used to fund the delayed payment pool. The aggregate supplemental payment amount for the 2018/19 rate year will be funded by a pool of $88,000,000, of which $4,000,000 will be used to fund the delayed payment pool. Ninety (90) percent of the remaining amount will be used to compute the Tier 2 and 3 per diems in paragraph B.6, and the remaining ten (10) percent will be used to compute the improvement per diem in paragraph B.7. Annually, the pool amounts will be updated in the state plan and will be based on funds derived from the general fund related to setting aside 1% of the weighted average Medi-Cal per diem rate, plus the savings from the Professional Liability Insurance being applied at the 75th percentile and the administrative penalties collected for facilities' failure to meet the nursing hours per patient day requirement, minus administration costs.

9. The 2017/18 delayed payment pool will be used to fund delayed QASP payments which are made after the primary payment, but before June 30, 2019. The 2018/19 delayed payment pool will be used to fund delayed QASP payments which are made after the primary payment, but before June 30, 2020. An example of a delayed payment would be where a facility was originally determined to be ineligible in accordance with paragraph C.a, at the time of primary payment, but such determination was later successfully appealed by the facility within the above timeline. Delayed supplemental or improvement payments will be made on a per diem basis at the respective per diem rate established by the respective rate year calculation. No rate year's per diem calculations will be altered by delayed payments, and no payments originally made to other facilities will be affected by delayed payments. A facility eligible for a delayed payment will receive the established Tier 2 or Tier 3 per diem, based on its own quality of care score. A facility eligible for a delayed payment will receive the established improvement per diem, if its improvement score ranks in the top 20th percentile when included in the ranking of all eligible facilities. Any remaing funds from the delayed payment pool will be applied to the following rate year's aggregate supplemental payments amount. If the amount in the delayed pool is insufficient to pay all computed delayed payments for the current Fiscal Year, additional funds will be made available by deducting from next Fiscal Year's total payment pool so that all facilities eligible for a delayed payment will be paid their computed payments in full.

C. For each applicable rate year beginning August 1, 2017, the Department will pay an annual lump sum Medi-Cal supplemental payment (as computed in paragraphs B.6 and B.7 above), by April 30th of the applicable rate year, (and delayed payments by June 30th of the year following the end of the applicable rate year as provided in paragraph 9 on page 23), to eligible skilled nursing facilities, based on the following performance measures as specified in W&I Code Section 14126.022 (i), as in effect on June 2016:

1. Facility Acquired Pressure Ulcer: Long Stay
2. Physical Restraints: Long Stay
3. Influenza Vaccination: Short Stay
4. Pneumococcal Vaccination: Short Stay
5. Urinary Tract Infection: Long Stay
6. Control of Bowel/Bladder: Long Stay
7. Self-Reported Pain: Short Stay
8. Self-Reported Pain: Long Stay
9. Activities of Daily Living: Long Stay
10. Direct Care Staff Retention
11. 30 Day All-Cause Readmission

a. The Department will determine a facility ineligible to receive supplemental payments if the facility fails to meet the following minimum qualifying criteria:

   i. A facility fails to timely provide supplemental data as requested by the Department.

   ii. CDPH determines that a skilled nursing facility fails to meet the nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code.

   iii. For the performance period, facility has Class AA/A citations. These citations are issued due to serious harm or death of a resident.

   iv. For the audit period, facility does not have any Medi-Cal bed days. Furthermore, facility must have Medi-Cal Fee-For-Service bed days in the payment period in order to receive a Medi-Cal Fee-For-Service supplemental payment.